



Professional Medical Spa
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PATIENT INFORMATION AND MEDICAL HISTORY

In order to provide you with the most appropriate treatment, we need you to complete the following questionnaire. All information is strictly confidential.

Personal Information

Patient Name _____ Today's Date _____

Date of Birth _____ Age _____ Gender Male Female

Home Address _____

City _____ State _____ Zip Code _____

Home Phone () - _____ Work Phone () - _____

Occupation _____

E-mail Address _____

Would you like to receive our specials via e-mail once per month? We do not share your e-mail address. Yes No

Emergency Contact Name and Phone _____

How were you referred to us? _____

Dermatologic History

Are you currently under the care of a dermatologist? Yes No

If yes, for what: _____

Name of dermatologist: _____

Which of the following best describes your skin type?

- | | |
|--|---|
| <input type="checkbox"/> I Very Fair: Always burns, Never tans | <input type="checkbox"/> IV Olive: Rarely burns, Always tans |
| <input type="checkbox"/> II Fair: Burns easily, Sometimes Tans | <input type="checkbox"/> V Brown: Rarely burns, Tans profusely |
| <input type="checkbox"/> III Light Olive: Rarely burns, Usually tans | <input type="checkbox"/> VI Dark Brown: Never burns, Tans profusely |

Have you ever had skin cancer? Yes No

If yes, what kind? _____

Has anyone in your family ever had skin cancer? Yes No

If yes, what kind? _____

Do you regularly sun bathe or use tanning salons? Yes No

If yes, how often? _____

What skin care products have you used in the past? _____

Do you have a history of erythema ab igne, which is a persistent skin rash produced by prolonged or repeated exposure to moderately intense heat or infrared irritation? Yes No

Have you had any recent tanning or sun exposure that changed the color of your skin? Yes No

Have you recently used any self-tanning lotions or treatments? Yes No

Do you form thick or raised scars from cuts or burns? Yes No

Have you ever had laser hair removal? Yes No

Have you ever had Botox® injections? Yes No

Have you ever had dermal filler injections (for example, Juvéderm, Restylane)? Yes No

Have you used any of the following hair removal methods in the past six weeks (check all that apply)?

Shaving Electrolysis Tweezing Depilatories

Waxing Plucking Stringing

Do you have hyperpigmentation (darkening of the skin) or hypopigmentation (lightening of the skin) or marks after physical trauma? Yes No

If yes, please describe. _____

Medical History

Are you currently under the care of a physician? Yes No

If yes, for what: _____

Do you have a pacemaker? Yes No

Do you have any of the following medical conditions? (Please check all that apply)

Arthritis Frequent cold sores Any active infection Any neurological disorder

Asthma Heart Condition Bleeding disorder AML (Lou Gehrig's disease)

Cancer Hepatitis HIV/AIDS Lambert-Eaton syndrome

Diabetes High blood pressure Hormone imbalance Myasthenia gravis

Eczema Keloid scarring Skin disease/Skin lesions Parkinson's disease

Glaucoma Kidney disease Thyroid imbalance Seizure disorder

Hay fever Liver disease Psychiatric disorder

Herpes Autoimmune disease

Do you have any other health problems or medical conditions? Please list:

Have you ever had an allergic reaction? (List any and all that you have had and describe the reaction you experienced)

- Food Aspirin Hydrocortisone Hydroquinone or skin bleaching agents
 Latex Lidocaine Animal Protein Others: _____

Have you ever been diagnosed with body dysmorphic disorder that you are aware of? Yes No

Medications

What oral prescription medications are you presently taking? Birth control pills Hormones

Others (It is required that you list all of them): _____

Are you currently taking any aminoglycoside antibiotics: amikacin (Amikin®), gentamicin (Garamycin®), kanamycin (Kantrex®), neomycin (Mycifradin®), netilmicin (Netromycin®), paromomycin (Humatin®), streptomycin, or tobramycin (TOBI solution®, TobraDex®, Nebcin®)? Yes No

Are you currently taking D-penicillamine? Yes No

Are you currently taking any anti-malarial medications? Yes No

Are you currently taking any immunosuppressive medications? Yes No

Have you ever taken isotretinoin (Accutane)? Yes No

If yes, when was your last dose? _____

Are you taking any blood-thinning medications such as aspirin, Coumadin (warfarin), ibuprofen or motrin, non-steroidal anti-inflammatory drugs, or products containing Ginko biloba? Yes No

What antibiotics do you use to treat infections? _____

Do you take any medications for glaucoma or increased intra-ocular pressure? Yes No

If yes, which ones? _____

Do you take any medications for heart conditions? Yes No

If yes, which ones? _____

Are you on any mood altering or anti-depression medication? Yes No

If yes, which ones? _____

What topical medications or creams are you currently using? Retin-A , Others (Please list):

What herbal supplements do you use regularly? _____

Surgical History

Have you ever had surgery? Yes No

If yes, please list all surgeries: _____

Obstetrical and Gynecological History

For female patients only.

Are you pregnant or trying to become pregnant? Yes No

Are you breastfeeding? Yes No

Are you sexually active? Yes No

Are you using contraception (birth control pills, condoms, IUD, abstinence)? Yes No

Have you gone through menopause? Yes No

What was your last menstrual period? _____

Social History

Do you smoke? Yes No

If yes, how many packs per day? _____

How long have you been smoking for? _____

Do you drink alcohol? Yes No

If yes, what type and how much? _____

I certify that the preceding medical, medication and personal history statements are true and correct. I am aware that it is my responsibility to inform the doctor or other health professional of my current medical or health conditions and to update this history. A current medical history is essential for the caregiver to execute appropriate treatment procedures.

Signature: _____

Date: _____

For patients under the age of 18, parental signature is required below.

Parent Name: _____

Signature: _____

Date: _____